

## **§ 9792.6. Utilization Review Standards—Definitions**

(a) As used in this section:

(1) “ACOEM Practice Guidelines” means the American College of Occupational and Environmental Medicine Practice Guidelines, Second Edition.

(2) "Claims Administrator" is a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer securing its liability under subdivision (b) or (c) of Section 3700 of the Labor Code, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(3) “Concurrent review” means utilization review conducted during an inpatient stay.

(4) “Emergency care” means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(5) “Expedited review” means utilization review conducted when the employee’s condition is such that the employee faces an imminent and serious threat to this or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the employee’s life or health or could jeopardize the employee’s permanent ability to regain maximum function.

(6) "Health care provider" means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, or a member of a preferred provider organization or network.

(7) "Medical services" means those goods and services provided pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

(8) “Prospective review” means utilization review conducted prior to the delivery of medical services.

(9) "Request for authorization" means a written or oral request for a specific course of proposed medical treatment set forth in the Medical Treatment Authorization Request (Optional Form to Expedite Review), Form DLSR 5021, Section 14006, or in the format required for Primary Treating Physician Progress Reports in subdivision (f) of Section

9785. An oral request for authorization must be followed by a written request within seventy-two (72) hours.

(10) "Retrospective review" means utilization review conducted after medical health services have been provided.

(11) "Utilization review plan" means the written plan filed with the Administrative Director pursuant to Labor Code section 4610, setting forth the policies and procedures, and a description of the utilization process.

(12) "Utilization review process" means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600. Utilization review does not include determinations of the work-relatedness of disease, or bill review for the purpose of determining whether the medical services were accurately billed.

(13) "Written" includes an electronic facsimile or electronic mail subject to applicable privacy laws, as well as communications in paper form.

#### **§ 9792.7. Utilization Review Standards—Applicability**

(a) Effective January 1, 2004, every insurer shall establish and maintain a utilization review process for all dates of services, regardless of date of injury, in compliance with Labor Code Section 4610. Each utilization review process shall be set forth in a utilization review plan which shall contain:

(1) The identity of the employed or designated medical director, who holds an unrestricted license to practice medicine in the state of California issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code.

(2) A description of the process whereby requests for authorization are reviewed, and decisions on such requests are made, and a description of the process for handling requests expedited reviews.

(3) A description of the specific criteria utilized in the review and throughout the decision-making process, including treatment protocols or standards used in the process. It shall include a description of the personnel and other sources used in the development and review of the criteria, and methods for up-dating the criteria. Prior to and until the Administrative Director adopts a medical treatment utilization schedule pursuant to Section 5307.27, the written policies and procedures governing the utilization review process shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition.

(4) A description of the qualifications and functions of the personnel involved in decision making and implementation of the utilization review plan.

(b)(1) The medical director shall ensure that the process by which the insurer reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with this section.

(2) No person, other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the licensure and scope of the physician's practice, may, except as indicated below, delay, modify or deny, requests for authorization of medical treatment for reasons of medical necessity to cure or relieve the effects of the industrial injury.

(3) A non-physician reviewer may be used to initially apply specified criteria to requests for authorization for medical services. A non-physician reviewer may approve requests for authorization of medical services. A non-physician reviewer may discuss applicable criteria with the requesting physician, should the treatment for which authorization is sought appear to be inconsistent with the criteria. In such instances, the physician may voluntarily withdraw a portion or all of the treatment in question and submit an amended request for treatment authorization, and the non-physician reviewer may approve the amended request for treatment authorization. Additionally, a non-physician reviewer may delay requests for authorization of medical treatment to reasonably request appropriate additional information that is necessary to render a decision, but in no event the delay shall exceed the time limitations imposed in Section 9792.9 subdivisions (a)(1) through (a)(3). Any delay time beyond the time specified in these paragraphs is subject to the provisions of paragraph (5) of Section 9792.9.

(c) The complete utilization review plan, consisting of the policies and procedures, and a description of the utilization process, shall be filed by the insurer with the Administrative Director and shall be disclosed to employees, physicians, and the public upon request.

#### **§ 9792.8. Utilization Review Standards—Medically-Based Criteria**

(a)(1) The criteria shall be consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, the criteria or guidelines used in the utilization review process shall be consistent with the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, Second Edition.

(2) For all conditions or injuries not covered by ACOEM Practice Guidelines or by the official utilization schedule after adoption pursuant to Section 5307.27, authorized treatment must be in accordance with other medical treatment guidelines generally recognized by the medical community that are developed with involvement of actively practicing health care providers, and are evaluated annually.

(3) The criteria used shall be disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review. The insurer may not charge an employee or the employee's physician for a copy of the criteria or guideline used to modify, delay or deny the treatment request.

(4) The criteria or guidelines used in the utilization review process shall be available to the public upon request as follows:

(A) The insurer is only required to disclose the criteria or guidelines for the specific procedures or conditions requested.

(B) The insurer may charge members of the public reasonable copying and postage expenses related to disclosing the criteria or guidelines pursuant to this paragraph. Such charge shall not exceed \$0.25 per page plus actual postage costs.

(C) The insurer may make available the criteria or guidelines through electronic means.

#### **§ 9792.9. Utilization Review Standards—Timeframe, Procedures and Notice Content**

(a) The utilization review process shall meet the following timeframe requirements:

(1) Prospective or concurrent decisions shall be made as soon as possible, but not to exceed five (5) working days from the receipt of the information.

(A) If appropriate information which is necessary to render a decision is not provided with the original request, such information may be requested to make the proper determination, but in no event the determination shall be made more than 14 days from the date of the original request by the provider.

(B) The request for authorization must be in written form. For purposes of this section, the written request for authorization shall be deemed to have been served on the claims administrator on the date the request was successfully faxed or the date the request was successfully electronically transmitted subject to applicable privacy laws.

(C) Where the request for authorization is made by mail, and a proof of service by mail exists, the request shall be deemed to have been served on the claims administrator five (5) days from date of mailing consistent with the time requirements of Code of Civil Procedure Section 1013(a). In the absence of a proof of service by mail, the request shall be deemed to have been served on the claims administrator on the date-stamped as received on the document.

(D) If the reasonable appropriate information requested by the claims administrator is not received within 14 days of the date of the original request by the provider, the claims administrator may deny the request with the stated condition that the request will be reconsidered upon receipt of the information requested.

(2) When review is retrospective, decisions should be communicated to the physician who rendered services and to the individual who received services, or to the individual's designee, within 30 days of receipt of the medical information that is reasonably necessary to make this determination. Failure to obtain prior authorization for emergency services shall not be an acceptable basis for refusal to cover services rendered to screen and stabilize an injured worker presenting for emergency care.

(3) Prospective or concurrent decisions related to expedited review should be made within 24 hours of the date of the medical treatment recommendation by the physician, but in no event shall be made more than 72 hours after the receipt of the information reasonably necessary to make the determination. Decisions related to expedited review referred to the following situations:

(A) When the employee's condition is such that the employee faces an imminent and serious threat to this or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or

(B) The normal timeframe for the decision making process, as described in paragraph (1) of this section, would be detrimental to the employee's life or health or could jeopardize the employee's permanent ability to regain maximum function.

(4) Decisions to approve, modify, delay or deny request by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to the employees shall be communicated to the requesting physician within 24 hours of the decision. Any decision to modify, delay or deny request shall be communicated to the physician initially by the telephone or facsimile. The communication by telephone shall be followed by written notice to the physician and employee within 24 hours for concurrent review and within two business days for prospective review.

(5) The review and decision to deny, delay or modify a request for medical treatment must be conducted by a physician, who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice.

(6) (A) The timeframes specified in paragraphs (1) or (2) of this section may only be extended by the insurer under the following circumstances:

(i) The claims administrator is not in receipt of all of the necessary medical information reasonably requested.

(ii) The claims administrator has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice.

(iii) The claims administrator needs a consultation and review of medical information by an expert reviewer.

(B) If (i), (ii) or (iii) above apply, the claims administrator shall immediately notify the physician and the employee, in writing, that the insurer cannot make a decision within the required timeframe, and specify the information requested but not received, the additional examinations or tests required, or the expert reviewer consulted. The claims administrator may request only information reasonably necessary to determine medical necessity from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization of treatment. The claims administrator shall also notify the physician and employee of the anticipated date on which a decision may be rendered.

(C) Upon receipt of all information reasonably necessary and requested by the claims administrator, the claims administrator shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) above.

(D) Every claims administrator shall maintain telephone access from 9:00 AM to 5:30 PM Pacific Standard Time, on normal business days, and maintain a process to receive communications from providers after business hours, for health care providers to request authorization for medical services. For purposes of this section “normal business day” means a business day as defined in Section 9 of the Civil Code. In addition, every insurer shall have a facsimile number and electronic mail address available for physicians to request authorization for health care services.

(b) A written decision approving a request for treatment authorization under this section shall specify the specific medical treatment service approved.

(c) A written decision to the physician modifying, delaying or denying treatment authorization under this section must contain the following information:

(1) The date on which the decision is made.

(2) The name of the reviewer, the telephone number of the reviewer, and hours of availability.

(3) A clear and concise explanation of the reasons for the insurer’s decision.

(4) A description of the medical criteria and the specific guidelines used.

(5) The clinical reasons for the decisions regarding medical necessity.

(6) State that any dispute shall be resolved in accordance with Labor Code Section 4062.

(7) Details about the insurer’s appeals process, if any, and clearly state that the appeals process is on a voluntary basis as consistent with Labor Code Section 4062(a).

(d) A written decision to the injured worker modifying, delaying or denying treatment authorization under this section must contain the following information:

(1) The date on which the decision is made.

(2) A description of the medical criteria or guidelines used.

(3) State that any dispute shall be resolved in accordance with Labor Code Section 4062, and that the injured worker may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWC Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance Section 10136(b)(1).

(4) Include the following mandatory language:

"If you want further information, you may contact the local state Information and Assistance office by calling [enter district I & A office telephone number closest to the injured worker] or you may receive recorded information by calling 1-800-736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits".

(5) Details about the claims administrator's appeals process, if any, and clearly state that the appeals process is on a voluntary basis as consistent with Labor Code Section 4062(a).

(e) Authorization may not be denied on the basis of lack of information without documentation reflecting attempt to obtain the necessary information either by facsimile or electronic communication or by mail to the physician.

#### § 9792.10. Utilization Review Standards—Dispute Resolution

(a) If the request for authorization of medical treatment is not approved, or if the request for authorization for medical treatment is approved in part, any dispute shall be resolved in accordance with Section 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of Section 4062(b). Nothing in this paragraph precludes the parties from participating in an internal utilization review appeal process on a voluntary basis as consistent with Section 4062(a). Additionally, the injured worker may file an Application for Adjudication of Claim, and a Request for Expedited Hearing, DWC Form 4, and request an expedited hearing and decision on his or her entitlement to medical treatment.

(b) The following requirements shall be met prior to a decision to deny authorization for medical treatment and to resolve disputes:

(1) In the case of concurrent review, medical care shall not be denied until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care shall continue until certification of medical necessity is determined.

(2) Medical care provided during a concurrent review shall be medical treatment that is reasonably required to cure or relieve from the effects of the industrial injury.

#### § 9792.11. Utilization Review Standards—Penalties

(a) The Administrative Director, or his or her deligee, may conduct routine or targeted audits pursuant to Labor Code §§ 129, 129.5, 4610 and California Code of Regulations, Title 8, § 10106.1(c)(6).

(b) If the Administrative Director, or his or her deligee, determines that the insurer has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director pursuant to Labor Code § 4610, may assess, by order, administrative penalties for each failure pursuant to Section 10111.2(b)(28). These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

#### § 9792.12. Utilization Review Standards—Medical Confidentiality Policy

(a) All activities involving utilization review are subject to applicable state and federal law affecting confidentiality.

#### AUTHORITY:

Note: Authority cited: Sections 129, 129.5, 133, 139, 4604.5, 4610 and 5307.3, Labor Code. Reference: Sections 129, 129.5, 3211, 3702, 4062, 4600, 4603.2, 4610 and 5307.1, Labor Code.